Application

Fill out this form to apply for PCIP **and** MRMIP. **Answer** all questions to ensure the application is complete. **If you do not provide all the necessary information, the processing of your application may be delayed.** When you see this arrow ►, it means you may have to send supporting documents.

1 Tell us about the person who needs coverage. ☐ New enrollment ☐ Add dependents

Legal Last name:	Legal First name:	Middle initial:
Date of birth (month/day/year):	Gender: ☐ Female ☐ Male	
Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Registered Domestic Partner		
Home address:	Are you a California resident? ☐ Yes ☐ No	
City: / State: / ZIP code:	Telephone number:	
Email address:	Cell phone number:	
Mailing address *(if different from your home address):*		
City: / State: / ZIP code:		
► Are you a U.S. Citizen or U.S. National? ☐ Yes ☐ No *If **Yes**, send documentation (see application checklist on page 7).*	**Social Security Number** (**Required for PCIP, If U.S. Citizen or U.S. National**) :	
► If you are **not** a U.S. Citizen or U.S. National, are you lawfully present in the U.S.? ☐ Yes ☐ No *If **Yes**, send documentation (see application checklist on page 7).*		
What language do you want us to use when speaking with you?	How many people are in your family?	
What language should we use when writing to you?	What is your annual household income?	

Tell us about your ethnicity *(optional)*

☐ White ☐ Black, African American

Hispanic: ☐ Cuban ☐ Mexican, Mexican American ☐ Puerto Rican ☐ Other Hispanic _____

Asian: ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Japanese ☐ Amerasian ☐ Korean ☐ Laotian ☐ Vietnamese ☐ Filipino ☐ Other Asian _____

Pacific Islander: ☐ Hawaiian ☐ Guamanian ☐ Samoan ☐ Other Pacific Islander _____

☐ Aleut / Alaska Native ☐ American Indian, Native American ☐ Eskimo

Other, not listed above _____

2 This is an application for PCIP and MRMIP. Tell us which health insurance program you prefer.

If you qualify for **both** PCIP and MRMIP, which one do you want to be enrolled in? Check only one box: ☐ PCIP ☐ MRMIP
*If you qualify for both and **do not select a program**, we will enroll you in PCIP.*

If you're approved for PCIP and your complete application was received after the 15th, your coverage will be effective the first day of the second month. However, you can choose an earlier coverage effective date (See FAQ on page 22 of the handbook).

☐ If I qualify, please enroll me with an earlier coverage effective start date.

3 Tell us how you learned about PCIP or MRMIP.

How did you learn about PCIP or MRMIP? *(Check all that apply.)*

☐ Insurance Agent/Broker ☐ Community clinic ☐ Health insurance denial letter ☐ Employer
☐ Certified Application Assistant ☐ Website / Internet ☐ Hospital ☐ Church
☐ Health Fair / Community Event ☐ Pharmacy ☐ Friend / relative
☐ Disease management organization ☐ Doctor's office ☐ Government office ☐ Other _____

4 Information for MRMIP coverage

If you qualify for MRMIP, which health plan do you want? *(see pages 16–21)* ☐ Anthem Blue Cross ☐ Contra Costa ☐ Kaiser Permanente

► Were you covered by a similar high-risk insurance program in another state within the last 12 months? ☐ Yes ☐ No

If you do not qualify for MRMIP right now but expect to qualify soon, are you applying for deferred enrollment? *(see page 23)* ☐ Yes ☐ No
*If **Yes,** please provide the following information:*

Name of current insurance company, health plan, or health program:	Date your coverage started:
Reason for future termination:	Date your coverage will end:

► If you are applying for deferred enrollment, send a copy of a letter from your health insurance plan indicating when your coverage will end.

Have you met the requirements to avoid all (or part) of the MRMIP exclusion/waiting period? *(see page 24)* ☐ Yes ☐ No
*If **Yes,** please fill in the information below:*

Name of prior insurance company, health plan, or health program:	
Date that your coverage started:	Date that your coverage will end:

► If you have met the requirements to avoid all (or part) of the exclusion/waiting period, send a copy of your health insurance policy, health plan document, or proof that you had coverage (including Medicare and Medi-Cal) indicating when your coverage ended.

5 If you are applying for MRMIP and want coverage for dependents, list the dependents here.

*PCIP does **not** provide coverage for dependents. Each person interested in PCIP must complete a separate application. He or she must qualify to be enrolled.*

Name of dependent Last, First, Middle Initial, **and** SSN (optional)	**Gender** Female or Male	**Date of birth** Month/Day/Year	**Married?** Yes or No	**Relationship to applicant** Check one:
1.	☐ F ☐ M	/ /	☐ Y ☐ N	☐ Spouse ☐ Child ☐ Stepchild ☐ Registered Domestic Partner ☐ Child of Registered Domestic Partner ☐ Other _____
2.	☐ F ☐ M	/ /	☐ Y ☐ N	☐ Spouse ☐ Child ☐ Stepchild ☐ Registered Domestic Partner ☐ Child of Registered Domestic Partner ☐ Other _____
3.	☐ F ☐ M	/ /	☐ Y ☐ N	☐ Spouse ☐ Child ☐ Stepchild ☐ Registered Domestic Partner ☐ Child of Registered Domestic Partner ☐ Other _____

► If a dependent child is over 23 years old, send a doctor's letter with the application for each child over 23 stating that the person cannot work because of a continuous physical or mental disability that started before age 23. The dependent child cannot be married.
Is the dependent child (who is over 23 years old) covered by Medicare? ☐ Yes ☐ No

Have any of your dependents met the requirements to avoid all (or part) of the exclusion/waiting period? *(see page 24)* ☐ Yes ☐ No
*If **Yes**, list their names below:*

Name of dependent	Name of prior health insurance company	Date coverage started	Date coverage ended
1.		/ /	/ /
2.		/ /	/ /
3.		/ /	/ /

► If the dependent has met the requirements to avoid all (or part) of the exclusion/waiting period, send a copy of the health insurance policy, health plan document, or proof that you had coverage (including Medicare and Medi-Cal) indicating when his or her coverage ended.
If you have more dependents, photocopy page A2 and fill it out. Send the additional pages with your application.
Subscriber dependents age 18 and under are not subject to the pre-existing condition exclusion period or the post-enrollment waiting period.

6 Tell us about your recent health insurance experience that qualifies you for PCIP or MRMIP.

For PCIP: Within the past 6 months, have you had **any** health coverage? ☐ Yes ☐ No

*If **Yes,** please indicate by checking the boxes below, and indicate the date your health coverage ended* _____ /_____ /_____.
mo day yr

- ☐ Another PCIP program *(see page 20)*. If so, which state: _____
  - ☐ Check this box if you obtained other health coverage **after** you were disenrolled from another PCIP program.
- ☐ Individual or job-based health coverage, including COBRA or Cal-COBRA
- ☐ Medicare Part A and Part B
- ☐ Medi-Cal (Medicaid)
- ☐ Children's Health Insurance Program (CHIP), including the Healthy Families Program (HFP)
- ☐ Another state's high-risk pool or California's Major Risk Medical Insurance Program (MRMIP)
- ☐ TRICARE (military health insurance)
- ☐ Health benefit plan provided to Peace Corps workers
- ☐ Health coverage provided by a public health plan established by a state, the U.S. government (such as coverage provided to veterans enrolled in VA health care), or a foreign country
- ☐ FEHBP (health insurance for federal employees or retirees), including Temporary Continuation of Coverage (TCC)
- ☐ Services provided by the Indian Health Service or by a Tribe or Tribal organization for treating your medical condition
- ☐ **Any other coverage (please specify) :** _____

If you had health coverage within the past 6 months, please provide the reason your health coverage ended.

- ☐ You or someone in your family lost or left his or her job
- ☐ Your insurance company stopped covering dependents
- ☐ You or someone in your family stopped working full time and were no longer eligible for benefits
- ☐ You moved out of the insurance company's service area (or moved out of state)
- ☐ Your insurance premiums were too high
- ☐ Your COBRA coverage ended
- ☐ You voluntarily ended your insurance coverage
- ☐ You are no longer eligible for publicly sponsored coverage
- ☐ Other. Explain the reason your coverage ended:_____
  _____

▶ **For PCIP and MRMIP:** Have you received a denial letter from a health insurance company or health plan within the past 12 months? *If **Yes,** provide a copy of the **denial letter**.* ☐ Yes ☐ No

▶ **For MRMIP:** Within the past 12 months, have you received an offer of individual (not group) health coverage at higher rates than your selected MRMIP health plan? *If **Yes**, provide a copy of the **offer letter**.* ☐ Yes ☐ No

▶ **For MRMIP:** Have you been involuntarily terminated from health insurance coverage for reasons other than fraud or nonpayment of premium? *If **Yes**, provide a copy of the **termination letter**.* ☐ Yes ☐ No

▶ **For PCIP:** Within the past 12 months, have you received an offer of individual (not group) health coverage at higher rates than the MRMIP PPO product? *If **Yes**, provide a copy of the **offer letter**.* ☐ Yes ☐ No

▶ **For PCIP:** Have you received a letter from a licensed doctor, physician assistant, or nurse practitioner within the past 12 months, stating the individual has or had a medical condition, disability or illness? *If **Yes**, provide a copy of the **provider letter**.* ☐ Yes ☐ No

▶ **For PCIP:** Have you ever been told that you should not apply for a specific health care insurance by an employer; health insurance company; or insurance agent/broker? *If **Yes**, provide more information below.* ☐ Yes ☐ No

Name of employer or health insurance company or insurance agent/broker:

Address:	Phone:

City:	State:	ZIP code:

7 PCIP dispute resolution and MRMIP health plan dispute

In **PCIP**, there are rules for resolving disputes about delivery, services, and other matters. To find out how PCIP resolves disputes, you can call PCIP at 1-877-428-5060, or refer to the Summary Plan Description booklet on our website at **www.pcip.ca.gov**.

In **MRMIP**, each plan has its own rules for resolving disputes about delivery, services, and other matters. Some plans say you must use binding arbitration for disputes (not including disputes with the program about which benefits are covered); others do not. Some plans say that claims for malpractice must be decided by binding arbitration; others do not. If the plan you choose requires binding arbitration, you are giving up your right to a jury trial and cannot have a dispute decided in court. To find out how a plan resolves disputes, you can call the plan and request an Evidence of Coverage booklet. To see which MRMIP plans require binding arbitration, see page 9.

8 Important notices and declarations, and understandings and responsibilities

I declare that I have read this application, the answers provided, and the documents enclosed. I certify that the information provided with this application is true, complete, and correct to the best of my knowledge. I have read and understand the Notices, and I am making the Declarations on page 9. I have also read and I understand the MRMIP health plan dispute resolution **and** PCIP dispute resolution explanation on page A3.

Signature of applicant/parent or legal guardian ▸▸ _____ Date: _____

If you are a parent or legal guardian of the person applying for coverage, you must sign above and provide the following information:

Full name:	Telephone number:
Mailing address:	
City:	State: ZIP code:

Check your relationship to the person applying for coverage: ☐ Parent ☐ Stepparent ☐ Caretaker Relative ☐ Legal Guardian

☐ Other _____

For **MRMIP only**, the dependent(s) listed on this application must sign here:

Signature of applicant's spouse/registered domestic partner: _____ Date: _____

Signature of applicant's dependent age 18 or over: _____ Date: _____

Signature of applicant's dependent age 18 or over: _____ Date: _____

9 Permission to share PCIP and MRMIP information

I give permission for PCIP **or** MRMIP to give information over the telephone about my application status and final eligibility status to the person listed below.

Person's Name:	EE/CAA Number: (if applicable)
CA Agent/Broker License Number (if applicable):	

Applicant's signature ▸▸ _____ **Date:** _____

10 For Insurance Agents/Brokers or Certified Application Assistants (CAAs) only:

If you assisted an applicant in completing this application, this section must be completed. **You must fill out all applicable boxes.** You will **not be paid** if you do not fill out this section **prior to sending the application.** ***Missing information*** **cannot** be submitted at a later date for payment. (See page 22 of the handbook.) If the applicant wants PCIP or MRMIP to provide you with the status of this application and final eligibility decision, make sure the applicant fills out and signs Section 9 above.

Agent/Broker/CAA name:			Entity to be paid:
Street address:			City:
State:	ZIP code:	Phone:	Email address:
CA Agent/Broker License Number:			CAA Number:
Tax I.D./Social Security Number (Agent/Broker only):			EE Number:

I understand that payment **will not** be made unless and until this applicant is enrolled in the program. I certify that I provided free assistance to the applicant.

Agent/Broker or CAA signature: _____ **Date:** _____

Rev: 12/12

Important Notices and Declarations

PCIP and MRMIP Declarations

- I understand that it is my responsibility to inform PCIP of any health coverage I get in the future or if I move out of California, so that I can be disenrolled.
- I understand that my premium payment must be received by the due date even if I do not receive a billing statement.
- I understand that, if I voluntarily disenroll from PCIP or if I am disenrolled involuntarily (for example, for failure to pay my premiums on time), I may not re-qualify for enrollment until at least 6 months after my coverage ends.
- I understand that my application and enrollment information may be shared with other Federal and State government agencies for purposes of establishing PCIP eligibility.
- I understand that my application and enrollment information may be shared with the California Health Benefit Exchange (HBEX) for the purposes of facilitating enrollment in health coverage through the HBEX.
- I understand that my application must be reviewed to determine whether or not I qualify for coverage.
- I understand that, if my application is approved, the effective date of coverage will be determined according to applicable laws and regulations and I will be informed in writing of the effective date of coverage.
- I understand that the MRMIP health plan dispute resolution process may include binding arbitration, rather than a court trial to resolve any claim. This includes a claim for malpractice asserted by me, my enrolled dependents, heirs, personal representatives, **or** someone with a relation to us against the participating health plan or against the employees, partners or agents of the participating health plan.
- I understand that MRMIP's Contra Costa Health Plan DOES NOT require binding arbitration.
- I understand that MRMIP's Anthem Blue Cross and Kaiser Permanente Health Plans DO require binding arbitration of disputes INCLUDING malpractice, so long as the disputes are beyond the jurisdictional limit of the small claims court. This does not include disputes with the program about which benefits are covered.
- I understand that if I do not provide all the necessary information requested to process the application, the application will be denied or returned as incomplete.
- I declare that, within the last 6 months, I have not had health coverage prior to the date I am asking for coverage in the PCIP.
- I declare that all individuals listed on this application are residents of the State of California.
- I declare and understand that making a monthly premium payment does not mean that I am accepted by, or, if accepted, immediately enrolled into, the programs.
- I declare that no person listed on this application and applying for MRMIP is eligible for both Medicare Parts A and Part B, unless they are solely eligible because of end-stage renal disease.
- I declare that no person listed on this application and applying for PCIP is enrolled in Medicare Parts A and B.
- I declare that all individuals listed on this application will abide by all rules of program participation.
- I declare that no person listed on this application and applying for current or deferred enrollment into MRMIP is currently eligible to purchase any continuation of employer health benefits under the provisions of 29 U.S. Code 1161 et seq. (COBRA), **or** under the provisions of Insurance Code Sections 10128.50 et seq. and Health and Safety Code Sections 1366.20 et seq. (Cal-COBRA). These are laws which allow people to buy into their employer's health insurance for up to 36 consecutive months after they leave their employment.
- I declare that no person listed on this application and applying for PCIP is enrolled in COBRA or Cal-COBRA.
- I declare that no person listed on this application, and applying for coverage through the MRMIP, was terminated within the last 12 months from a "Post-MRMIP Guaranteed Issue Pilot Program" as a result of non-payment of premiums, a request to disenroll voluntarily, or fraud. A "Post MRMIP Guaranteed Issue Pilot Program" is a health plan in which an individual had an opportunity to enroll between September 1, 2003 and December 31, 2007 as a result of being disenrolled from MRMIP after 36 consecutive months of enrollment.
- I declare that I have read and understand the information on this Application and agree to these Notices and Declarations.

Access to Your Records

You have the right to access records maintained by the Managed Risk Medical Insurance Board that contain your personal information. To do so, contact:

Managed Risk Medical Insurance Board
Attn: HIPAA Coordinator
P.O. Box 2769
Sacramento, CA 95812-2769
(916) 324-4695